# WellcomeHistory

ISSUE 31 **SPRING 2006**




wellcome trust

# AIDS in Britain

## Public health, fear and information: a media view

**THOMSON PRENTICE**

**Soon after I joined *The Times* in 1983, the editor, Charles Wilson, with whom I had already shared many journalistic years, proposed that I should become the newspaper's medical reporter.**

I protested that I knew nothing about medicine. He reminded me of my numerous reporting assignments abroad. "You've been a foreign correspondent," he said brusquely. "Think of medicine as a foreign posting. Go there, get to know the country, and deliver the news from it. It's as simple as that."

Wilson was an astute, seasoned newspaper man, tutored like me in the hard, competitive school of Scottish journalism. He realised that to a general readership, health issues were becoming increasingly important. They were, in his view, no longer the exclusive domain of the doctor-columnists who at that time were employed by all broadsheet newspapers. "I'd rather have a good journalist who isn't a doctor than a good doctor who isn't a journalist," he said.

Neither he nor I could know quite what a foreign land the reportage of AIDS would become. Today, more than 20 years later, over 40 million people worldwide have HIV, and it is almost impossible to recall how little most of us knew then.

In Britain, at the end of 1984, there were fewer than 100 cases; Terrence Higgins, the first British fatality, had died in 1982. Nobody knew where AIDS was going. It was foreign territory for everyone: mysterious, unexplored, complex and menacing. All we understood was that a sinister new disease was spreading and killing people, particularly those in groups beginning with the letter 'H' – homosexual men, haemophiliacs and, because of a cluster of cases in that country, Haitians. The notion that a further 'H' – for heterosexuals – was involved was controversial and deeply resisted across most of British society.

AIDS provoked more extreme prejudices than perhaps any disease before or since. Gay men with AIDS were regarded as having brought the disease upon themselves, while others – the non-homosexual cases – were looked upon as 'innocent victims'. It was a disease of 'them' and not 'us'; it was the 'gay plague'.

For serious newspapers such as *The Times*, AIDS was a minefield to be traversed almost daily. On one hand it was an important 'running story' and the papers wanted plenty of it. On the other, it was easy to blow it up. The most explosive issue was the threat of a heterosexual epidemic, but nobody knew how likely that really was. HIV was only newly discovered and there was persisting ignorance of the variety of ways in which it could be transmitted – and where it was spreading fastest. Forecasters were predicting tens of thousands of cases in Britain within the coming few years. The World Health Organization (WHO) was starting to talk in terms of millions of deaths worldwide.

Tabloid newspapers were zooming in on the most sensational stories, fed by the AIDS-related deaths of celebrities such as actor Rock Hudson and pop musician Freddie Mercury. Notable figures, such as The Princess Royal, would make public pronouncements about the 'own-goal' culpability of people with AIDS, while her sister-in-law, Princess Diana, would provide photo opportunities by shaking (ungloved) hands with hospitalised patients and being seen with gay icons such as Elton John. Medical journalists' best sources were a handful of scientists, doctors and researchers,

**Above:**
Electron micrograph of HIV, budding from T lymphocyte.

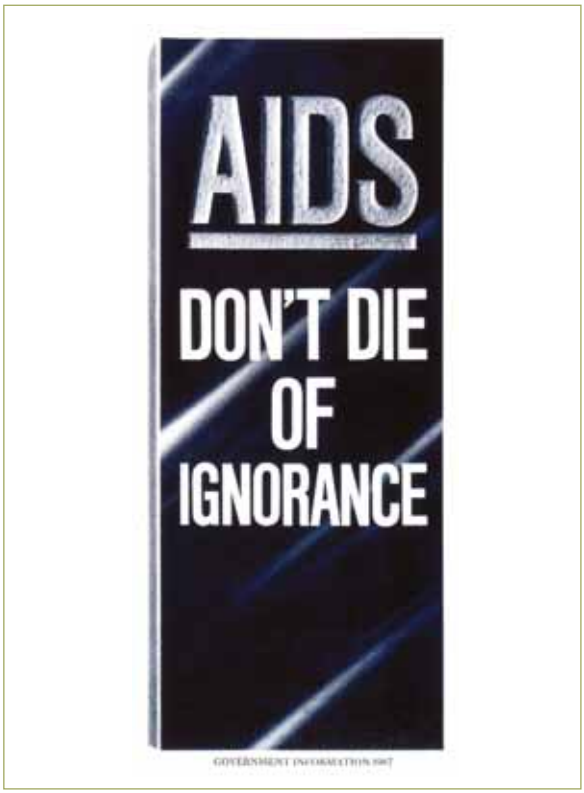
**Cover:**
Allegorical cartoon by Nicholas Garland, the *Independent*, 1988.

special-interest advocacy groups, the Department of Health press office and the WHO.

In this media world that existed before the internet, the laptop and the mobile phone, we seemed to be always rushing by taxi or Tube from one press conference to another, scribbling our notes, dictating our hastily written stories across the phone to copy-takers in our newspapers. Every week we impatiently waited for the *Lancet* and the *British Medical Journal* to be biked to our offices by special messengers so we could race through the latest medical and scientific studies.

I believe the British corps of medical journalists did a responsible job, most of the time. The main challenge was how to report the AIDS epidemic accurately and responsibly, and it took us far into unknown territory. We had to navigate our way through extremely complicated virology, research studies and epidemiological projections, entrenched prejudice and stigmatisation, expert and lay opinions, together with a genuine and widespread lack of actual knowledge.

All these elements made balanced reporting of AIDS a daily voyage of chance. It required application and stamina to understand the whole gamut of issues, from the scientific to the political and the social. It meant learning who the best experts in the field really were, cultivating them as contacts and winning their trust. It meant separating facts from opinions and propaganda. Striving for balance on a tightrope, it sometimes meant resisting pressures from editors to take the story this way or that. Most of all, perhaps, it meant trying to judge whether the British Government was getting it right or wrong – and whether we, the media, were as a consequence causing the public unjustified concern.




**Right:**
AIDS leaflet from the Department of Health and Social Security, 1987.

We had begun to perceive not just that AIDS was capable of heterosexual spread, but that in a global context, this was the main form of transmission. Most people did not want to hear this message, but the Department of Health went to great lengths to enforce it. Between 1986 and 1990, it spent £32 million on mass press and television publicity campaigns employing icebergs and gravestones as key images, with messages such as "AIDS – don't die of ignorance", and dispatched grim leaflets through 23 million letterboxes to every household in the country. Condoms were included in press packs and handed out at scientific conferences. Countless health education initiatives were launched.

We looked to the WHO for the global evidence, and in particular to its charismatic expert on AIDS, Jonathan Mann. He had served his time in sub-Saharan Africa, and was an unmatched global campaigner for preventative action against the disease. I came to know him well and followed his immense, driving energy to many an international conference. He kept urging us to focus on the epidemic in other continents, particularly Africa. The gathering evidence that AIDS originated in Africa and was causing an unprecedented human tragedy there took me on an assignment to Burundi, Rwanda and Zaire (as was). I encountered national officials struggling to understand the crisis in their midst, saw the impoverished health facilities at the front line of the epidemic, met researchers trying to make sense of the epidemiology, and sensed the deep hurt that many Africans felt about their perceived stigmatisation by the Western world. It was for me a daunting, humbling, sometimes harrowing experience.

Ultimately Jonathan Mann fell foul of internal politics at the WHO, and abruptly resigned in 1990. To the end, his media skills did not desert him: he faxed me a copy of his resignation letter on the same day he submitted it to his superiors. A few years later he was on a flight from New York to Geneva that crashed, killing all on board, in the north Atlantic.

Meanwhile, by the late 1980s, the AIDS epidemic in Britain failed to materialise on the predicted scale. Transmission of HIV remained predominantly among the 'high-risk' groups of intravenous drug injectors and men having sex with other men. The much-feared breakthrough into the heterosexual population never happened. Expert predictions of cases were seen to be far off the mark. The monthly statistics were reassuringly low. By 1990, eight years after the first recorded case, the total of all cases was about 4000, with about 15 000 others known to be HIV positive. Public information campaigns were scaled down. Within another year or two, government commitment to AIDS prevention was visibly on the ebb.

It is probably impossible to measure the real impact those government campaigns had on curbing the epidemic, how much they changed sexual behaviour in Britain and how many deaths they prevented. The Department of Health made many miscalculations


**Above:** Roadside poster in Malawi. *N Durrell McKenna*

during these crucial years. But it deserves credit nevertheless for quickly taking the potential impact of AIDS and the risk of heterosexual spread very seriously – to the point of overstating it – and for influencing its political masters. It was surely better to stir alarm than to encourage complacency.

But as with every cause for alarm, complacency crept back. The story went from the front page to deeper and deeper into the middle sections of *The Times* and other newspapers. Editors, journalists and readers lost interest and turned their attention to other popular health issues – test-tube babies, organ transplants, *Salmonella*, hospital-acquired infections, and the general debate over the decline of the NHS. Meanwhile, tens of millions were becoming infected with HIV in Africa and Asia, but in the UK, how many people really cared? It was, once again, a foreign story.

Thomson Prentice joined the WHO in Geneva as a media relations officer in 1992 and went on to become managing editor of the annual *World Health Report*, a post he holds today. In addition, he coordinates the WHO Global Health Histories Initiative, whose partners include the Wellcome Trust Centre for the History of Medicine at UCL, UK (**E** prenticet@who.int).

**Footnote: By the end of 2005, there had been a cumulative total of almost 22 000 diagnoses of AIDS in the UK, of whom more than 13 000 had died. An estimated 58 300 individuals in the UK were living with HIV, almost 20 000 of whom were unaware of their condition. Newly diagnosed cases reported for 2004 stand at 7275. The main increase is among heterosexuals (the majority of whom probably acquired the virus in Africa), with 4287 new diagnoses in 2004, accounting for 59 per cent of that year's total. (Source: National AIDS Trust, 1 December 2005.)**

# Preventing tuberculosis in 20th-century India

**NIELS BRIMNES**

**Tuberculosis is not a disease that we normally associate with tropical countries such as India. Rather, we tend to see it as a problem particularly related to the damp and crowded industrialised cities of 19th-century Europe.**

During the 20th century, however, TB became a major health problem in India. It was also an issue that brought out a number of preventative as well as curative strategies. Notably, TB attracted the attention of the newly created World Health Organization (WHO) and UNICEF in the years immediately following Indian independence. Studying the attempts to control TB in India throughout the 20th century allows us to get an impression of the changes in health regimes as the century advanced, and, more particularly, to study the formative years of international health strategies within a decolonising world.

TB was not regarded as one of the major diseases in India in the early years of the 20th century. Perhaps this was because the disease was less common in India than in the urban centres of Europe, but it might also be owing to a lack of awareness of this disease, which is relatively difficult to identify. The first extensive treatment of TB in India was written by Dr Arthur Lankester in 1920, by which time the disease was seen as rapidly advancing in India and – according to Lankester's estimate – the cause of one in every seven deaths in India. In 1933 the Public Health Commissioner stated that TB had become an epidemic disease and ranked it next to malaria as the most important health problem in the country. Around mid-century it was estimated that India had 2.5 million active cases of TB and that the disease caused half a million deaths every year.

Up to independence the strategy adopted to control TB in India was based on isolation of cases and treatment in clinics, hospitals and sanatoria. Given the economic, social and demographic realities in India, it was impossible to implement this strategy on a scale that could make an impact on the prevalence of TB. To combat the disease through a general rise in the living conditions of the millions of poor people in late colonial India was an even more distant goal. Within the first few years after independence, however, two possible and promising alternative strategies emerged: BCG vaccination and chemotherapy.

BCG vaccination was offered to countries outside Europe by the Scandinavian-directed (but mainly UNICEF-funded) International Tuberculosis Campaign (ITC) in 1948, and the Government of India entered into an agreement with the ITC in November 1948 – the first non-European country to do so. The ITC worked in India between early 1949 and mid-1951, vaccinating 1.6 million children and adolescents. In this period it had to design logistics and vaccination techniques

suitable for a populous country with a poor infrastructure, as well as tackling medical and popular resistance to the vaccine in some areas. In 1951, UNICEF and the WHO took over from the ITC, and today – despite doubts about its efficacy – BCG is still part of the Indian vaccination programme.

At the same time, efficient antibiotic drugs against TB were developed, such as streptomycin. It then became a major challenge to create cheap and efficient drugs that could be administered in individuals' homes. In this way the treatment of TB would no longer demand expensive hospitalisation and sanatorium treatment. With the purpose of conducting research towards this goal, a WHO-supported Tuberculosis Chemotherapy Centre opened in Madras in 1956 under the direction of the British and Indian Medical Research Councils.

By the 1960s there were several complementary – but also competing – TB control strategies available for the Indian health authorities. A preventative strategy was based on the controversial BCG vaccine, a curative strategy was based on relatively expensive drugs, and finally the most ambitious strategy was to ameliorate the living conditions for millions of poor people in India. It is my hope that further research connected to this project will provide new insights into the problems inherent in each strategy as well as into the interplay between them.

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# Population control, Scandinavian aid and Indian family planning

**SUNNIVA ENGH**

**Developing-country population growth emerged as an issue in aid policy from the early 1950s, reaching a peak in the 1960s and 1970s with a widespread sense of an imminent 'population explosion' impeding all development efforts in recently independent countries and other so-called 'underdeveloped' areas.**

Gradually, and reluctantly, an increasing number of Western donor countries incorporated family planning assistance into their aid programmes, with the USA, Sweden and Norway being notably generous in this respect.

The historiography of international population control has argued that a predominantly American 'network of knowledge', consisting of scientists, politicians and philanthropic foundations, was crucial in linking demographic knowledge to development efforts and placing the need to limit population growth rates on the political agenda. It has been pointed out that this focus on US participants implies that "Americans monopolized agency and influence flowed only one way" – leaving out important international dimensions. First, support for population control measures was not unusual within elites in recipient countries, and so it is misleading merely to talk of a one-way influence. Secondly, as my doctoral project aims to show, influence did not just come from the USA. Although the American impact on the population matter is indisputable, it is important to note that other actors' initiatives pre-dated official American efforts by more than a decade. Scandinavian representatives raised the issue through the UN in 1952, and funded family planning efforts in Sri Lanka and India from the mid-to-late 1950s. These early initiatives prepared the ground for more comprehensive efforts, breaking the silence on a topic that all other aid donors had found too controversial to handle.

Previous historical works being based mainly on American sources, the Scandinavian examples point to a need to use a wider range of material for the writing of this history. Such an approach also shows that influence ran several ways, as when in the mid-1960s Swedish population experts were engaged to convince the US Senate of the need to include family planning in the American aid programme. It has been argued that, by 1960, "the American public was ready to support an overt neo-Malthusian movement" – which makes it important to ask why the Scandinavian public was ready ten years earlier.

My doctoral project examines why Sweden and Norway, with their small domestic populations and low birth rates, took a great interest in the population growth of the developing countries. The project is a comparative analysis of Swedish and Norwegian interest in and assistance for family planning, particularly investigating the countries' aid to India in the period 1965–95, using hitherto unexamined sources.

Scandinavian interest in family planning in developing countries can be related to earlier domestic encounters with population control, and to policies established during the inter-war period. A widespread belief in scientifically based social planning enabled a comprehensive social reform programme comprising eugenics, sterilisation policies and pro-natalist measures. These may be seen as formative experiences, making Scandinavian

governments more willing to support population control abroad. The connection is supported by the existence of direct links between the two policy areas. In Sweden, Alva Myrdal and Elise Ottesen-Jensen had a decisive impact on Swedish population control in the 1930s; two decades later, they were central to the planning of Sweden's first bilateral population control project. Karl Evang played a similar role in Norway, having a crucial impact both on domestic policies and in Norwegian aid to India, as well as promoting family planning through the World Health Organization.

When aid programmes were launched in the early 1950s, fear of a 'population explosion' became closely related to a key motivation for providing aid: security concerns. From a small-country perspective, aid was understood as an investment in a peaceful future, since inequality was seen as a cause for conflict. Within a Cold War framework, reducing developing-country population growth rates further acquired a sense of urgency. The inexperienced Scandinavian aid administrations maintained close connections with American philanthropists, particularly in the population matter. In addition, Swedish and Norwegian aid administrators saw themselves as particularly suited to providing family planning aid, as the countries had comparatively few religious or moral reservations about birth control.

Their interest in population programmes was initially directed at countries in the South Asia region, and after receiving requests for population aid from India in 1962 (Sweden) and 1967 (Norway), the two countries supported the Indian family planning programme. The support for population control was strengthened by the growing focus on women in development during the 1960s and 1970s, another area in which Sweden and Norway took early initiatives. However, when aid to India was dramatically escalated in the early 1970s, a more immediate reason was the rapidly expanding Scandinavian aid budgets, owing to the aim of reaching an expenditure of 1 per cent of the countries' GDP.

Swedish and Norwegian population aid to India ensured a strengthening of the population control facilities, predominantly sterilisation facilities, at more than 1500 hospitals. After the Indian Emergency of 1975–77, the donors made dramatically different decisions regarding their support: Sweden ended cooperation in 1980 as a result of pressure from public opinion, while Norwegian transfers increased sharply, and cooperation lasted until 1995. In the mid-1990s, Sweden and Norway drastically reduced their aid to India, and the country lost its status as a priority country. The official explanation has been India's comparatively high level of economic development; however, the termination of aid has also been related to India's testing of nuclear weapons. If this is the case, Scandinavian aid to India should again be viewed within a perspective of security and a wish to promote international stability.

The Indo-Scandinavian cooperation on population control highlights the fact that most decisions on the aid process were made according to aims and considerations on the donors' side. Indian wishes and priorities had very limited influence on the bilateral cooperation, and the overall Swedish and Norwegian budgetary priorities were paramount throughout the process.

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# The Global Project on the History of Leprosy

**JO ROBERTSON**

**The great success of the work against leprosy has developed out of international cooperation between a number of key and fairly diverse organisations, but how many know of the origins of this sometimes tense, but ultimately productive, collaborative endeavour?**

After the third *Conférence Internationale de La Lèpre* (Strasbourg, 28–31 July 1923), the League of Nations formed a Commission for the Study of Leprosy in order to investigate the extent of the disease, the success of various treatments, and the feasibility of uniform policies on the disease. In Paris, on 14 May 1928, the Commission decided that "more information was required on the prevalence of leprosy in various countries and on the methods of prevention". The interests of the Commission were also partly influenced by concern that the disease would spread from countries where it was endemic to those where it no longer presented a problem.

Although very few people remember this Commission, there were several enduring outcomes. The foundation of the International Leprosy Association (ILA), the publication of the *International Journal of Leprosy*, and the International Leprosy Congresses that are held every five years can all be traced directly to the international coordination that followed on from the meetings of the Commission and the activity of its Commissioner Étienne Burnet.

The archives through which these determining activities can be traced are located in the League of Nations Archives at the UN in Geneva (see page 20). One of the intentions of the Commission was to publish an

annual digest of leprosy information for those interested, worldwide. To this end, a questionnaire was sent to every country throughout the world; many responded with reports, photographs, and plans of their institutions. Part of the archive therefore quite literally represents a snapshot of work being done in such places as Surinam, Fiji, Macao and Malaysia, to mention a few. Photographs of children receiving oral doses of chaulmoogra in Paramaribo, Surinam, can be seen side-by-side with photographs of patients sitting before the open-air cinema in the Federal Leper Settlement in the Straits Settlements of the Federated Malay Straits.

## Culion was leading the world in leprosy research, especially in work with children.

One of the Commission's functions was to foster connections between medical people working in various parts of the world – although these connections had also been made previously through conferences in Berlin (1897) and Bergen (1909), the publication *Lepra* that came to a halt during World War I, and the work of the British Empire Leprosy Relief Association and its publication *Leprosy Notes* (which subsequently became *Leprosy Review*). One of the outstanding figures of this time was an American, Dr Windsor Wade, who was based at the largest of the leprosy colonies that existed at that time. Culion, a tiny island in the north of the Palawan islands in The Philippines, held over 5000 people affected by leprosy. Wade had been running the Culion Medical Society meetings for the medical staff on the island. It was through contacts with him and other notable contributors to leprosy research and work that the initiatives leading to the formation of the ILA took place.

Culion was leading the world in leprosy research, especially in work with children. It was uncertain how the disease was transmitted. The numbers of births on Culion, while presenting concerns about the transmission of the disease to the newly born, provided doctors on the island with a unique opportunity to study the impact of the disease on children. The records of these children are still held on Culion. The 'List of Released Patients from Culion Leper Colony (Discharged, paroled or released as non-lepers)' shows individual records, mostly of non-leprous children, usually with a photograph of the child on the left-hand side of the page and a typewritten summary of the case on the right. The photograph is accompanied by a record of name, date and place of birth, names of parents who were inmates of the colony, details of presentation to the examining committee with their notes, the laboratory report, and the decision for release: "non-leper". The records were made between 1924 and 1936.

A release form and an adoption paper complete the individual records. Through the release document, the child would be surrendered on condition that the duties of guardianship would be properly assumed. These included care, protection, support and education. The forms were signed before the Assistant Chief Culion Leper Colony Ex-officio Justice of the Peace and Notary for the Culion Reservation. There are hundreds of these. Children were handed over to relatives, friends, grandmothers, a parent who might have been an ex-inmate, and sometimes to unrelated adopting parents.

The Global Project on the History of Leprosy, the initiative of the ILA and funded by the Nippon Foundation, is based at the Wellcome Unit for the History of Medicine at Oxford. This project traces such archival resources as can be located in the League of Nations Archives, contributes to the preservation of endangered and vulnerable archives such as those on Culion, and supports and coordinates oral history initiatives, such as that undertaken in Fiji.

In an initiative coordinated by Dr Arturo Cunanan and sponsored by the Sasakawa Memorial Health Foundation and the Nippon Foundation – in conjunction with the Municipality of Culion, and archivist and academic Ricky Punzalan and his students from the University of The Philippines – the records on Culion are being preserved for future generations; Culion itself is preparing for its centenary celebrations next year. The ILA Global Project on the History of Leprosy has played a role in bringing these various interests together and acting as consultant for this activity.

In August 2004, Dr Jane Buckingham (a historian at the University of Canterbury in Christchurch, New Zealand, whose specialist topic is leprosy in India) and Dorothy McMenamin were commissioned by the Project to interview people who had been on Makogai, a Fijian island that used to house a leper colony. They visited Twomey Memorial Hospital in Suva, Fiji, to record the stories of people who had taken the brunt of past policies. The records of these interviews are with the archives of the Pacific Leprosy Foundation, at Macmillan Brown in Auckland.

The Project is dedicated to ensuring that the history of the work done against leprosy is not forgotten, and that the voice of the person affected by leprosy is heard. It will continue to be funded by the Nippon Foundation until May 2007. In the time remaining, there are many records to be located in order to do justice to the utterly unique history that the work against leprosy and the experiences of people affected by this disease reveal. The database already makes substantial material available to researchers with references to primary documents that should function as starting points for their work. The Project website (www.leprosyhistory.org) demonstrates both the geographical and the historical extent of the work against leprosy and indicates to anyone who has worked in the field what the gaps are and how much more work needs to be done before the records are preserved.

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# Obstetric anaesthesia in Britain, 1948–79

**RICHARD BARNETT**

**At the foundation of the NHS in 1948, a majority of British births took place in the mother's home. By 1979, the end of the Obstetric Anaesthetists' Association's (OAA) first decade of existence, most British mothers gave birth in hospitals.**

Not just the location of birth had changed, however. The ritual of the 'home confinement', attended by a local midwife and occasionally the mother's GP, was by the 1970s reconstructed as a medical procedure, overseen by consultant obstetricians and anaesthetists, and requiring a huge technological armamentarium – ultrasound scans, *in utero* fetal heart monitoring and the ubiquitous epidural – as well as the increasingly widespread use of a major surgical procedure in the form of the caesarean section. The pre-war definition of 'abnormal' birth – that which required management in hospital – was expanded to include, according to one prominent obstetrician, two-thirds of all pregnancies. Within this 'high-tech' paradigm, the management (ideally the elimination) of pain became the subject of great interest not only for mothers but also for physicians, midwives, scientists, politicians and the press.

**Above:** Childbirth in the UK.

But this is not the whole story. In discussing this subject one must take great care to avoid two assumptions. The first is that mothers themselves were passive, indiscriminate consumers of whatever type of care was offered to them by the state and the medical profession. This is clearly not the case: their agency in this matter is apparent both individually and collectively throughout the period.

Second is the assumption, more complex and more difficult to disentangle, that hospital birth was from the beginning imposed upon unwilling mothers by the medical profession. Press reports, correspondence and the archives of women's groups (such as the Association for Improvements in the Maternity Services, AIMS) show that in the 1950s many mothers regarded hospital birth as safer and more enjoyable than home birth, and campaigned vocally for their right to it. However, in the same period Dr Grantley Dick-Read and others opposed the notion of childbirth as an inherently painful process best controlled by physicians, promoting home-based 'natural childbirth' with relaxation techniques rather than drugs to kill pain. By the mid-1960s AIMS for one had abandoned its belief in hospital birth and campaigned instead for home birth. As birth moved from home to hospital, obstetricians supplanted midwives as the professionals 'in charge' of birth, and the natural childbirth movement's claim that birth pain was in some part related to the stress of hospital birth was redeployed in what many midwives perceived as a struggle for continuing professional recognition and even existence.

My research examines the role of anaesthesia and analgesia (defined as pharmacologically based intervention to reduce or abolish pain) in the post-war shift from home to hospital birth, and its use as a rhetorical device in the campaigns for and against hospital birth. The cultural and political framework in which this shift took place – the foundation and expansion of a socialised medical system, the 'brave new world' of 1950s technological optimism, and the contrasting growth of a radical feminist movement in the 1970s being among many factors – has been widely and acrimoniously debated by two broadly opposing groups of scholars. From feminist historians, we have a victimising narrative of male obstetricians who, unable to experience birth themselves, set out to destroy the 'magic' or 'mystery' of the event for mothers by rendering it utterly subject to the clinical gaze; and from practitioner-historians, we are given the hospitalisation of birth as part of an unreconstructed account of medical progress.

The historiography of medical specialisation too is involved; though perhaps it is more accurate to talk here of sub-specialisation, as the term 'obstetric anaesthesia' implies. The OAA, founded in 1969 by a group of British and Irish consultant anaesthetists, does not appear to have been interested in creating a speciality in the sense described by George Rosen: it did not set entry requirements or create a qualification, did not implement a research or teaching programme, and did not establish a journal until the mid-1990s. For anaesthetists more generally, members of a comparatively junior and narrowly focused hospital speciality, the provision of pain relief for women in labour provided a first opportunity to expand their horizons (not to say their professional status and jurisdiction) beyond the doors of the operating theatre.

This project is sponsored by a joint Wellcome Trust Centre/OAA studentship.

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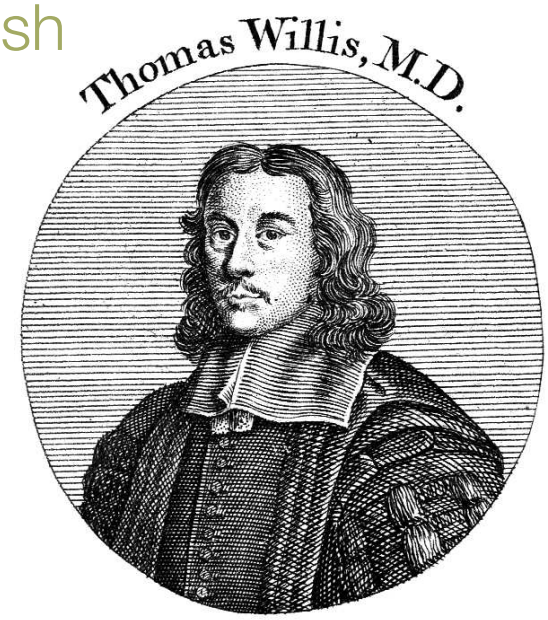
# The Association of British Neurologists, 1930–65

**STEPHEN CASPER**

**Histories of medical societies abound. Masses of celebratory tomes, manuscripts, articles, and archives from the 18th century to the present day have been preserved, and each source is invariably fascinating for the way it captures cultural styles of bygone epochs.**




**Right:** Line engraving of Thomas Willis by W Read, after D Loggan.

We find, for example, a Sheffield physician pondering in the late 19th century the fact that some past medical societies had been functioning as book clubs. The Sheffield Medico-Chirurgical Book Society, he remarked at a celebratory dinner, had "purchased books which were sent round to the different members, and then, at an annual dinner…disposed of by auction, the money obtained being again used for books in the ensuing year". To him the obvious overlap between past medical book societies and literary societies hinted at a regrettable loss of culture in the convivial settings of the medical clubs. Echoing this earlier sentiment was Humphrey Rolleston's 1928 address to the Nottingham Medical Society, which hinted at a newly emerging social dimension: "The uses of a medical society are many… in certain circumstances for combined action in medico-political crises." By the 20th century, political action appertained to the conviviality and communicative design of these societies as well.

Such a behavioural mosaic was typical to the Association of British Neurologists (ABN) as well. Founded in 1933, the ABN appeared in a period when neurology was emerging out of general medical departments in Britain's teaching hospitals and universities. The Association's charming dinners in swanky hotels, matched with rare but sometimes-brusque scientific debates, and still rarer

# New publication

*Old Potions, New Bottles: Recasting indigenous medicine in colonial Punjab (1850–1945)* by Kavita Sivaramakrishnan.

*Old Potions, New Bottles* is a study of how indigenous medical learning and practices were recast and reformulated with the coming of Western medicine and Western medical ideas through colonial rule. Analysing local responses to global enforcements in a specific yet massive terrain, namely colonial Punjab, Kavita Sivaramakrishnan explores the processes by which this region's Ayurvedic practitioners and publicists set about reordering ideas and mobilising networks in response to the claims of Western medicine and its implicit validation of colonial rule.

She shows that vaid practitioners engaged with the scientific authority of Western medicine in the colony through writings and other efforts in a print-based public sphere. Facing both threat and competition, local practitioners were forced to address and propagate new forms of medical reason to legitimate and revalidate the indigenous scientific basis of their learning. In part, this meant reinterpreting Ayurvedic claims to status and authority.

This book also explores the engagements between the Ayurvedic and Unani indigenous practices, thereby looking beyond the confining binaries of Asian and Western medical systems. It argues for an understanding of the contextual politics of indigenous medicine as a fluid and complex body of ideas as well as representations of religious identities and linguistic alignments. Vaid claims to patronage and representation now meant nothing less than recasting vaid identity in Punjab; this was marked by irregular alignments and multiple imaginings.

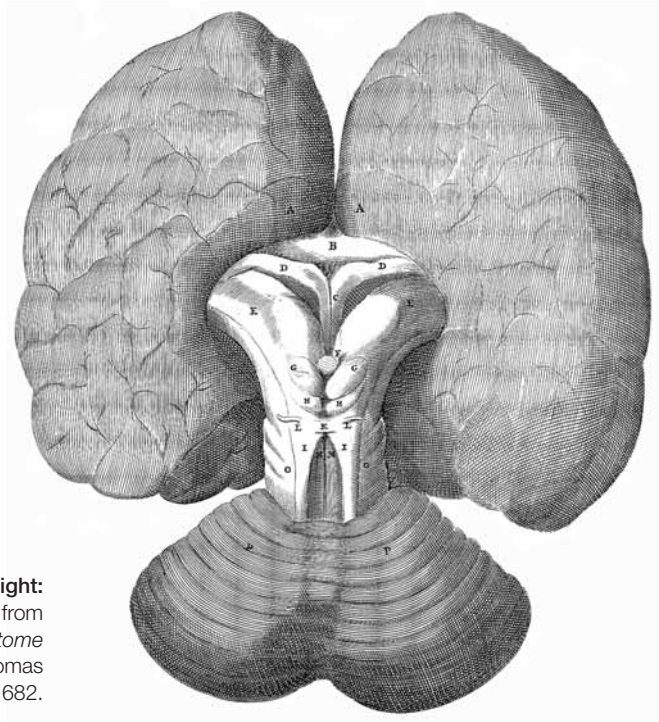
Drawing upon years of fieldwork across Punjab, Sivaramakrishnan examines, alongside the standard archives, a vast number of vernacular pamphlets, tracts and magazines (many previously unstudied). This is supplemented and enriched by interviews with Ayurvedic practitioners and families of hereditary practitioners, as well as data from private collections and diaries that have never been accessed until now.

Published in: New Perspectives in South Asian History, Orient Longman India Ltd (ISBN 81-250-2946-X).

For purchase in the UK and Europe, contact Anthony de Souza (**E** sangambooksuk@gmail.com); for the rest of the world, contact Orient Longman Private Ltd (**E** cogeneral@orientlongman.com).

political action, seem commonplace now. Less humdrum, however, was the Association's context in British medicine. I take up precisely this emergence of neurology, and probe the histories of ABN members, to explore the larger context of medical specialisation in Britain. Why the Association was founded, what professional identity its members maintained outside it, and what role it played in establishing institutions of neurology, suggest that a host of cultural, political and social negotiations occurred in both local and national settings to define the speciality in Britain. Moreover, these negotiations never solidified into a recognised definition for the speciality, which created significant challenges in subsequent decades.

Despite having a tradition some argue originated with contributions from Thomas Willis (1621–1675), neurology in Britain had until the 1920s been confined to three small specialist hospitals in London, all of which were founded in the late 19th century. Although much medical and scientific scrutiny had focused on the properties of the nervous system throughout the 19th century, the category 'neurologist' remained (even in 1920) rather under-recognised. It was typically one of a string of identifiers employed in the obituaries of elite physicians: "[he] was primarily a general physician but he made his scientific reputation chiefly in the fields of neurology, diseases of the heart and blood, and disorders of the endocrine organs". This lack of professional identity can be seen in the membership of Britain's earliest neurological society: the Neurological Society of the United Kingdom. This society, founded in 1886, had attracted an eclectic but nonetheless elite membership. Most would never have described themselves as specialists. In fact, in 1907, anti-specialist inclinations eventually drove them to amalgamate with the newly created Royal Society of Medicine, a society specifically constituted to keep medicine "whole".



**Right:** Illustration from *Cerebri anatome* by Thomas Willis, 1682.

This explicitly generalist political action revealed the existence of two rival medical cultures in Britain. More conservative physicians, fearing the trend of specialisation, warned that excessive research exuberance in the younger generation would bog medicine down in a swamp of details relatively inconsequential to the sick. Younger physicians, adopting a newer rhetoric, lauded progress in neurological science, and attributed successes in understanding and treatment of nervous diseases to, for example, a Thomas Lewis-styled paradigm of clinical research. By the 1930s, generalist criticism appeared medieval in comparison with the accomplishments the younger generation of physicians claimed. Many now desired positions as specialists and sought to change the social structure of a medical establishment that felt 'backwards' for its continuing adulation of the generalist.

Partly because of these issues, a small community of physicians split from the Royal Society of Medicine to form the ABN in 1933. Arguing the 250-strong membership of the Section of Neurology catered only to the London elite, the neurologists establishing the ABN pledged to include colleagues from provincial medical centres. A smaller society of 51 members was the result. This new community, more definite in its professional identity, appeared simultaneously with increased patronage for neurology from both state and philanthropic sources. A neurological research unit was established, neurological hospitals received endowments for research, and some general hospitals began receiving funding for neurological clinics.

By 1939 it seemed the institutional emergence of clinical neurology would be absolute within years. Oddly, the social transformation stagnated, and by 1955 the speciality, many practitioners felt, was in a state of collapse. With fewer than 70 neurologists scattered throughout Britain, marginal representation of neurologists in medical schools and universities, and GPs, neurosurgeons and psychiatrists allegedly pirating neurological patients, it seemed the speciality was lost in the medical sea. Funding for neurological research dried up, the most famous of the speciality's elite were retiring, and positions for postgraduates with training in neurology were nonexistent.

Meetings of the ABN continued, but the fire of the exchanges there, and more generally the excitement surrounding neurological research, sputtered. The conviviality typical of past medical societies continued, but the neurologists seemed incapable of political action. Neurology moved from crisis to crisis. Even in 1979 one professor remarked gravely: "the situation regarding...Neurology is indeed deplorable". No one was sure what or who was responsible; it was only clear that circumstances would have to change.

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# Medicine in medieval Deccan in the 15th to 17th centuries

**SALIL KADER**

**Medicine, healing and health have always been vital aspects of human existence. Their progress and development therefore form a necessary part of a comprehensive, historical study of any particular region or period.**

Historical analysis of these phenomena during the ancient and medieval periods of Indian history is made interesting by the fact that the scientific attitude was then less pervasive. Pre-modern societies, especially ancient and early medieval societies, had a tendency to look at most diseases as manifestations of supernatural, malevolent powers. In such a scenario, magico-religious traditions played an important role in tackling diseases and looking for cures. Despite this, there were marked efforts by individuals to respond with empirco-rational explanations to diseases hitherto attributed to demonic powers. It is this engagement between the magico-religious and empirico-rational traditions that makes the study of history of medicine in pre-modern societies such an interesting experience.

In terms of medical history, medieval Deccan presents a fascinating study. This is largely due to the fact that the region was then characterised by the presence of plural medical traditions that collaborated with each other. Apart from folk and tribal traditions, the Deccan was home to two other prominent systems of medicine, namely Ayurveda and Unani. Ayurvedic medicine was present in the Deccan from early times and was well established by the time Unani medicine entered the region, around the 14th century. Interaction between these two major systems of medicine was natural. A L Basham, describing the cooperation between the practitioners of the two systems, said: "whatever the *ulama* and the Brahman might say, we have no record of animosity between the Hindus and the Muslims in the field of medicine".

Unfortunately, researchers dealing with medicine in medieval India have increasingly tended to depict the interface between these two systems of medicine as being characterised more by the principle of repulsion than by the principle of attraction. This line of thought finds itself located within the historiographical school, which views the process of development of Hindu–Muslim relations as 'divisive' and the history of medieval India as a 'period of religio-cultural tensions'.

My research proposes to counter such biased histories by highlighting the ample evidence that reveals the growth of syncretic medical traditions that resulted from the interaction of Ayurveda and Unani. This interface greatly enriched both systems; it enhanced not only their *materia medica* but also their diagnostic practices. In fact, Ayurveda and Unani appeared to be following the same trajectory during the medieval period. According to Poonam Bala, this was so because of the "similar nature of their significant essentials and the support they received from the Muslim kings". Another noteworthy observation made by her is that Ayurveda and Unani never posed a threat to each other's existence, therefore helping them to retain their respective medical knowledge.

Apart from studying the nature of interaction between these medical traditions and their practitioners in medieval Deccan, I propose to deal with issues of disease and healing. Perceptions of disease, in the eyes of both the afflicted and the healer, and the methods of healing are dealt with in detail. Here, methods of diagnosis followed by the Ayurvedic vaid and Unani hakim are explored, along with the *materia medica* and pharmacopoeia associated with each system of medicine. This gives us a thorough comparative analysis of both systems in functional terms.

The Deccani Sultans were patrons of medicine and physicians, irrespective of their faith. The Bahmanis – followed by the five splinter Sultanates of the Qutb Shahis, the Adil Shahis, the Nizam Shahis, the Barid Shahis and the Imad Shahis – gave importance to medicine and healthcare in their own way. The Bahmani monarch, Sultan Alauddin Ahmad II (r. 1436–58) was the first Deccani ruler to get a hospital constructed at Bidar, catering to the needs of the sick and indisposed. The patronage provided by these rulers was a crucial factor for the numerous medical texts compiled in the Deccan during the medieval period.

The last part of my study deals with the new developments witnessed in the field of medicine with the coming of European medicine into the Deccan. The new traditions brought in, initially by the Portuguese and the French, then followed by the British, and the response of Ayurveda and Unani to European medicine, are brought out.

**Above:** Medical deity plate. *M de Fraeye*

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# Dust, disease and the politics of ill-health in the mid-20th century

**PAMELA DALE**

**This specialist symposium in September 2005, organised by the University of Exeter's Centre for Medical History and sponsored by the Wellcome Trust, was designed to pool expertise and identify themes and issues as a curtain-raiser for the major international dust conference being held in Exeter in April 2006.**

The key organising point was a concern with the availability and interpretation of sources that give insights into the health of miners (and other employees). In the first session Roger Burt (Exeter) discussed the dust hazards encountered in metalliferous mining in the South-west of England within the context of the complex calculations of risk and reward undertaken by the miners. The paper confirmed the value of exploring previously untapped sources, including insurance records, annuities and health clubs.

Reports from textile areas give a particularly rich description of working life within distinctive communities and environments.

Catherine Mills (Exeter) then introduced 'Parliamentary Papers as a Source for Understanding Occupational Health History: British metalliferous mining in the nineteenth and early twentieth centuries'. The paper emphasised the range of parliamentary papers available to studies of occupational health, but also frankly discussed their limitations in terms of using worker testimony to reveal attitudes and beliefs behind contemporary descriptions of workplace behaviours. Problems with sources, especially heroic tales of medically driven progress, were a key theme in the address by Joseph Melling (Exeter). Primary and secondary sources, in addition to some oral history testimony, were used to highlight medical debate on lung diseases during the inter-war period. Intellectual, institutional and political factors were shown to be a better guide to the chronology of developments than the apparent limitations of technical capacity and X-ray technology.

Arthur McIvor (University of Strathclyde) and Ronnie Johnston (Glasgow Caledonian University) expanded on the value of using oral history testimony, alongside archival sources, as an aid to understanding the causes and consequences of occupational dust disease. The methodology allowed for careful examination of lay knowledge of dust disease as well as understanding the impact of industrial disability. In the final session of the day, Ronald Frankenberg (Keele University) combined his own witness testimony arising from his experience of working for the National Union of Mineworkers in the 1950s with consideration of three different sociological approaches to the problem of disease. This provoked a very stimulating commentary from Julian Tudor Hart, who drew attention to the very different contributions of leading medical experts concerned with the problem of dust in the 1930s and 1940s.

The second day opened with an introduction to the important South Wales Coalfield Collection. Anne Borsay (University of Wales, Swansea) outlined its value as a resource for medical historians as well as for those concerned with the politics of the coal industry, giving an overview of her current project to survey the archives and make them more accessible through the publication of a new guide. Sara Brady (Swansea) then discussed some of her work on the project and shared some preliminary findings from the oral history archive, which includes more than 600 hours of taped interviews with miners, their families and community figures. Pamela Dale (Exeter) made the case for including analysis of public health priorities within studies of occupational health and suggested that reports by Medical Officers of Health were an under-utilised resource. Reports from textile areas give a particularly rich description of working life within distinctive communities and environments. Medical Officers of Health often had interesting ideas about dust and its impact on health inside and outside of the workplace, although their contribution to specific occupational health campaigns was far from straightforward.

The symposium was planned to coincide with the visit of Chris Sellers and Nancy Tomes (State University of New York) to Exeter, and Sellers brought the event to a conclusion with a broad overview of 'Workers and the Politics of Dust in an International Perspective'. In a wide-ranging discussion, he extended analysis from national studies to the relationship between hazards in developed and in developing countries. He found mixed evidence for 'race-to-the-bottom' models of production but illustrated complicated patterns of supply and demand for hazardous materials. This provoked a very stimulating question-and-answer session that led into an interesting round-table discussion, picking up themes and issues raised by all the different papers. The motivation of the different actors, and their understanding of dust hazards, was confirmed as a vital research agenda going forward.

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# Patients and pathways: cancer therapies in historical and sociological perspective

**ANDREW GARDINER**

**This workshop conference in October 2005 explored historical and sociological interpretations of cancer across time and place. The concept of 'patient pathways' was used to engage with the diversity of experience and meaning that cancer engenders.**

The event was organised by Carsten Timmermann and colleagues as part of their Wellcome Trust programme grant and was hosted by the University of Manchester's Centre for the History of Science, Technology and Medicine. Twenty papers examined a variety of cancers and explored issues surrounding diagnosis, treatment and research. In his introductory 'History of and for Patients', John Pickstone (Manchester) began from the vantage point of the 1970s and 1980s, when patient histories first emerged, and looked both backwards and forwards in time within the British NHS context to explore changing notions of patienthood.

Four papers were given on issues surrounding cancer diagnosis and treatment. Keith Wailoo (Rutgers University) looked at 'honest diagnosis' and the cultural politics surrounding patient communication in American medicine. Isabelle Baszanger (CERMES, Paris) presented results of her ethnographic research into late terminal cancer treatment in France. Near the 'threshold of death' she found patient pathways consisting of 'loops of time' in which treatment/palliation issues get continually renegotiated between doctor and patient in interactions that mobilise hope, silence and denial. Gretchen Krueger (Johns Hopkins University) discussed parental choice in the face of childhood malignant disease in America in the 1930s, at a time when medical, legal and social agencies began to work in concert on childcare, sometimes against parents' wishes. Two case studies of the treatment of 'glioma babies' were discussed, illustrating different pathways towards the diagnosis and treatment of retinoblastoma for the families concerned. Jason Szabo (Harvard University) discussed medical orientations to cancer care in the 19th and 20th centuries with reference to curable/incurable disease and palliation.

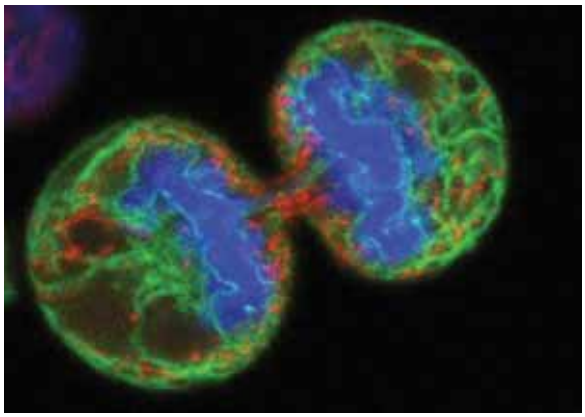
Barron Lerner (Columbia University) discussed one prominent patient's experience of acute myeloid leukaemia in America in the 1970s: Morris Abram's fight and survival subsequently became shaped, by himself and others, into a particular type of patient narrative emphasising optimism and deep involvement in the technicalities of available and experimental therapies. Emm Barnes (Manchester) considered research into chemotherapy for childhood cancer in the early 1960s, examining the dynamics of patient recruitment for experimental treatment regimes using three young patients' stories. These individual pathways are related to evolving professional networks, which in turn change the meaning of patienthood for those individuals and lead to a reappraisal of the role and impact of early clinical research to later treatments. On 'survivorship', Joanna Baines (Manchester) contrasted cancer as an event with cancer as a process and showed how these concepts could be applied to the experiences of different generations of patients and their pathways through the disease.

David Cantor (US National Library of Medicine and National Cancer Institute) explored the varied meanings of hope in the context of the 1950s campaign by the US Food and Drug Administration (FDA) against the alternative practitioner Harry Hoxsey. Using letters from the public in response to the FDA's efforts to discredit Hoxsey, the political use of hope in the battle between orthodox and unorthodox medicine was examined. The distinctive nature of cancer education in Britain in the first half of the 20th century was covered in Ornella Moscucci's (London School of Hygiene and Tropical Medicine) paper. Debates around cancer


education in public and professional rhetorics centred on varied meanings of hope, cure, prevention and early treatment; the result in Britain was a focus on educating the medical profession (especially community practitioners such as GPs, nurses and midwives) rather than the lay public. Kate Field (University of Oxford) described the audio and written resources on cancer patient narratives that have been collected as part of the DIPEx project, which may be of use to future historical study.

Gerald Kutcher (Binghampton University) presented the story of Maude Jacobs, one of a number of patients who received experimental whole-body radiation for breast cancer administered by Dr Eugene Saenger at the

**Right:** Advertisement for medicine claiming to cure cancer, 1912.



**Above:** Confocal micrograph of human melanoma cell undergoing division.
*PJ Smith and R Errington*

University of Cincinnati in November 1964. Maude's traumatic and tragic fate, and her inclusion in a study that was related to the effects of possible whole-body irradiation in service personnel, shows the patient as subject, object and finally martyr. Peter Keating (University of Quebec at Montreal) and Alberto Cambroso (McGill University) examined patients in protocols, describing how cancer (and other) patients can be grouped into different categories that are not mutually exclusive, such as 'last-chance patients', 'patients as a scarce resource' (for clinical research programmes), 'activist patients' and 'private patients'. US patient–protocol interactions by the mid-1980s can be understood as a network consisting of these patient groups, as well as community oncologists, clinical researchers, insurance companies, drug companies and oncology corporations. Research and treatment protocols therefore become seen as 'convergence points' for varied patient pathways through disease.

Ilana Löwy (CERMES) examined trends in the treatment of female cancers with respect to surgery and radiotherapy in various forms and combinations during the years 1920–60 in France and the US. When to choose which therapeutic option, and why, was explored in the context of 'surgical activism', the emphasis given to radiotherapy in France, as well as attempts to quantify the outcomes of difficult, sometimes unpredictable, diseases such as breast cancer with a view to selecting the best treatment pathway for an individual. Similar themes were discussed by Elizabeth Toon (Manchester) in relation to expanding treatment modalities for advanced breast cancer in Britain in the 1960s and 1970s. Problems in deciding what is classed as a 'response' in a disease with a variable natural history, and when, in the face of aggressive treatments, that response can be considered 'worthwhile' in patients who were likely to die from their disease, were examined. Carsten Timmermann's paper considered the surgical management of lung cancer using the story of Frank Craig, who suffered from the disease and was (in medico-pathological terms) a 'routine' lung cancer patient. Surgical treatment and success rates for lung cancer became static in the 1960s, and the paper explored the meanings of this for patients and surgeons. Treatment and palliation were discussed in a similar context to Baszanger's 'loops of time', the fluid and shifting nature of these categories at different phases of the disease being apparent in Frank Craig's story as written by his wife.

Charles Hayter (University of Toronto) described 'official' and 'unofficial' treatment pathways arising after the centralisation of cancer care in Ontario in the 1930s to 1960s, and highlighted the problems such a strategy caused for optimal patient care. Patrick Castel (GRESAC, Lyon) examined peer relationships in French oncology and suggested that an understanding of these informed sociological analysis of the therapeutic relationship in cancer diseases. Teun Zuiderent-Jerak and Roland Bal (Erasmus University, Rotterdam) described their ethnography of work practice in an oncology tertiary referral hospital in The Netherlands. Their aim is to redefine ideas of standardisation and patient-centredness in such a way that these previously mutually exclusive concepts can be brought together for patient and staff benefit in a system under stress.

Andrew Gardiner is a doctoral student attached to the Centre for the History of Science, Technology and Medicine, University of Manchester.

## New publication

*Reproductive Health in India: History, politics, controversies* edited by Sarah Hodges.

Within the scholarly fields of demography, development studies, medical anthropology and public policy, the history of reproduction in India has been dominated by preconceived and often ahistorical ideas about the country's supposed long-term trend towards 'over-population'. When these scholarly fields have invoked histories of fertility and contraception, the histories have largely been made to serve as the 'pre-modern' antitheses to a fully 'modern' future.

In contrast, this volume brings together historians to tackle the complex questions of reproduction in modern India. Taken together, these essays interrogate the very idea that reproduction is simply a linchpin for effecting other social and economic transformations. Instead, these histories map out and ask questions of the institutions, discourses and practices by which women's reproductive health came to hold meaning and play strategic roles in the multiple and at times competing agendas such as social reform, the medical sciences, cultural nationalism and colonial public health.

Published in: New Perspectives in South Asian History, Orient Longman India Ltd and Sangam Books UK (ISBN OL 81-250-2939-7 and SBUK 0-86311-8690).

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# Health education, public health and citizenship after 1945

**KELLY LOUGHLIN**

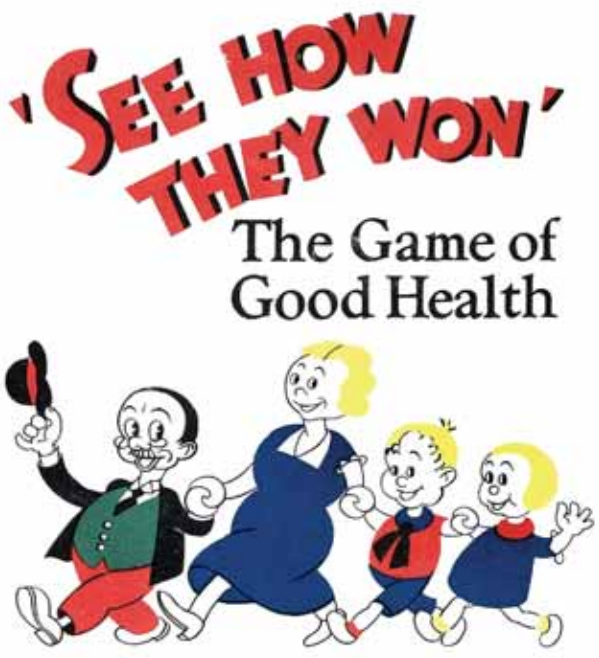
**At the close of the 20th century, health education was widely dismissed by the UK public health community as paternalistic and ineffective.**

Eclipsed by the rise of health promotion, 'traditional' health education was chided for its focus on individual responsibility and its neglect of the social determinants of health.

Indeed, the word 'education' failed to survive the century's last reorganisation of the field's national coordinating body, when in 2000 the Health Education Authority was transformed into the short-lived Health Development Agency. Health education within the education sector has followed a different trajectory and is currently framed in terms of personal and social development and citizenship.

The development of post-war health education, as well as its relationship to public health and notions of citizenship, was the subject of an afternoon workshop at the London School of Hygiene and Tropical Medicine (LSHTM) in November 2005. Organised by the Centre for History in Public Health, the workshop featured contributions from public health historians and those currently working in health education/promotion. Presentations were short and the wide-ranging discussion was chaired by Sarah MacLean (Head of the Personal, Social and Health Education and Citizenship Team at the Department for Education and Skills).

The afternoon began with an overview of post-war health education, presented by Kelly Loughlin (LSHTM).




**Below:** Cover of Boots Company board game, 'See How They Won', *c.*1930.

Here key points and themes were identified and seen to have characterised health education throughout the 20th century. Multi-sector involvement was a key feature, and one that pointed to many histories depending on topic (such as sex education) and the success of claims to legitimate involvement by different sectors (including voluntary groups and campaigners, commercial organisations, central and/or local government, mass media, and medical-professional bodies). Focusing on public health, two conflicting visions of health education were highlighted: health education as a form of salesmanship, akin to mass media commercial advertising; and health education as face-to-face communication requiring skills in group work. These models came into increasing conflict in the post-war era, reflecting central–local tensions within public health administration. Group work was stressed at the local level but greater central government involvement fostered a move towards mass media campaigns.

These themes resurfaced in the more topic-specific sessions that followed. James Hampshire (University of Sussex) provided a political history of post-war sex education policy. Here, policy making and the process of agenda-setting were brought to the fore in accounting for the way school-based sex education became an adversarial political issue. In policy terms, this issue had been relatively uncontroversial in the immediate post-war decades, framed as it was by a public health consensus that viewed sex education as a valuable tool in the control of sexually transmitted infections. From the late 1960s, this view came increasingly under threat as sex education became embroiled in wider attacks on the 'permissive society'. The public health consensus was forcibly challenged by moral traditionalists and 'pro-family' campaigners, who argued that sex education was not a solution but part of the problem. In rewriting the causal story, media-focused campaigners were effective in generating a polarised public debate that reverberates through to today.

The sensitivity of the topic, the nature of the target audience and the use of the media were themes carried forward in Virginia Berridge's (LSHTM) presentation. Here, the post-war rise and fall of central government involvement in health education was outlined. Pressure to address the problem of smoking was seen as pivotal in reorienting the public health agenda and government attitudes towards health education in the 1950s and 1960s. Mass media campaigns emerged as a central public health strategy, expressed through a new style of health communication using market research and advertising agencies. Government-funded agencies such as the Health Education Council (HEC) were founded to take this strategy forward at the national level, eclipsing more locally based traditions. This strategy intensified in the 1980s in response to HIV/AIDS. The unprecedented scale of the 1987 public campaign, and the replacement

of the HEC with the Health Education Authority (HEA), revealed continuing tensions over the nature, form and location of health education.

Criticism of the AIDS strategy, and debates over the 'de-gaying' and subsequent 're-gaying' of AIDS, point to the emergence of new and equally media-conscious voices in the health education arena. The lessons of AIDS also highlighted the benefit of keeping high-profile health education messages at a safe distance from Whitehall. By 2000 the HEA was transformed into the Health Development Agency, no longer tasked with public campaigns but with mapping the evidence base for public health.

Developments in community-based health education/promotion were taken up in the final session of the workshop. Chris Bonell (LSHTM) explored the problems and potential of voluntary-sector health promotion providers in regard to gay men's HIV prevention in the 1990s. This detailed case study brought notions of consumerism and citizenship to the fore in examining the strategies of a health promotion provider that sought to represent consumer interests. Here, the particularities of consumption were highlighted, rather than abstract notions of consumer interest, when explaining consumer action in connection with HIV services. Consumption became increasingly politicised through concerns over gay men's citizenship. The organisation in question adopted models of community mobilisation, workshops and outreach – a feature that highlights the centrality of concerns over citizenship, as well as the dispersed and often invisible nature of preventative service users.

The workshop was well attended, attracting a mixed audience of historians and practitioners. Participants enjoyed a lively and wide-ranging discussion on patterns of change and continuity in the history of health education.

Dr Kelly Loughlin is a Lecturer attached to the Centre for History in Public Health and the Department of Public Health and Policy, LSHTM, UK (**E** Kelly.Loughlin@lshtm.ac.uk).

# New publications

## Two new *Wellcome Witnesses to Twentieth Century Medicine*: 'The Recent History of Platelets in Thrombosis and Other Disorders' and 'Short-course Chemotherapy for Tuberculosis'.

Two major advances in medicine are discussed in the new Witness Seminar transcripts published by the Wellcome Trust Centre for the History of Medicine at UCL: the understanding of the role of platelets in coronary heart disease, and the introduction of a short (six-month) course of chemotherapy for the treatment of tuberculosis. Both relied heavily on the outcomes of large randomised controlled trials.

**'The Recent History of Platelets in Thrombosis and Other Disorders'**

The recent history of research on platelets started with the introduction of *ex vivo* methods for studying platelet behaviour. This recognition of platelets' role in haemostasis, and in both thrombotic and bleeding disorders, was furthered by Professor Gustav Born's invention and development of the optical aggregometer that bears his name. Discussion covered: the biochemistry and function of platelets; the platelet release reaction and the effect on it of aspirin; the Nobel Prize-winning discovery by Sir John Vane of how aspirin inhibits the natural production of prostaglandins; and the results of randomised controlled trials of aspirin and other thrombolytic drugs for the prevention of thrombotic conditions, including a discussion of the streptokinase trials, 1986–96. Contributors include: Professor Gustav Born, Professor Peter Elwood, Professor Rod Flower, Professor John Hampton, Professor Stan Heptinstall, Professor Desmond Julian, Professor Tom Meade, Professor Salvador Moncada, Professor Brian Pentecost and Dr Duncan Thomas.

**'Short-course Chemotherapy for Tuberculosis'**

The introduction in 1952 of isoniazid established the standard treatment of streptomycin, isoniazid and either thiacetazone or para-aminosalicylic acid for pulmonary tuberculosis. To achieve good results, patients had to take treatment for 18 or even 24 months under supervision. By 1970 a move towards short-course chemotherapy was made, owing partly to experimental work in mice at the Pasteur Institute (Paris) and partly to experiments in Professor Denis Mitchison's unit at the Hammersmith Hospital, along with the advent of rifampicin and the reappraisal of pyrazinamide. Finally, a series of large controlled clinical trials was carried out by the UK Medical Research Council in East and Central Africa, India, Singapore, Hong Kong and elsewhere. The trials showed that a remarkable and quite unpredictable simplification of treatment could be made, with major benefits. Chaired by Dr David Girling, this Witness Seminar brought together a group of experts who were involved in some of the major developments in the treatment of tuberculosis, including: Dr Joseph Angel, Dr Ian Campbell, Sir Iain Chalmers, Dr Kenneth Citron, Sir John Crofton, Professor Janet Darbyshire, Professor Alan Glynn, Dr Tony Jenkins, Dr Amina Jindani, Dr Jeanette Meadway, Professor Denis Mitchison, Dr John Moore-Gillon, Professor Andrew Nunn, Professor Peter Ormerod and Dr Knut Øvreberg. Mrs Gaye Fox attended on behalf of Professor Wallace Fox.

In line with the Wellcome Trust policy of open access to the published output of research, volumes 23 and 24 of *Wellcome Witnesses to Twentieth Century Medicine* are now freely available to download at www.ucl.ac.uk/histmed, following the links to Publications/Wellcome Witnesses. The records and tapes from both meetings will be deposited in GC/253, Archives and Manuscripts, Wellcome Library, London.

Hard copies are available from Amazon and all good booksellers.

# Medical theory and practice in South Asia

**MANJIRI N KAMAT**

**In the last few years there has been increasing interest in the history of medical theory and practice in a wide range of South Asian contexts. This scholarship has charted a new course by avoiding overgeneralised analyses while making a rigorous assessment of diverse historical sources.**

This day-long workshop in Hyderabad in August 2005, jointly organised by the Wellcome Trust Centre for the History of Medicine at UCL and Orient Longman India Ltd, celebrated these historiographical trends by bringing together a group of scholars who have contributed to the development of the discipline of medical history. Participants were encouraged to make a presentation on the basis of their most recent work, to locate their research findings in relation to the existing historiography, and to map out new research avenues and possibilities. The workshop was divided into three panels.

**Above:** Guide to tantric meditation and the flow of the life-force, prana, through the body, *c*.18th century.

The theme of panel 1 was plague in colonial Bombay. Mridula Ramanna (University of Mumbai) discussed state intervention and responses to plague in Bombay Presidency between 1896 and 1920. The measures for coping with the disease varied according to the exigencies of the situation, and Indian responses were mixed. She concluded that as a result of Indian opposition, state interventionism was abandoned after 1900 and there was a policy shift from cure to prevention. In the changed context, active involvement was sought from Indian doctors, political and community leaders, as well as voluntary organisations.

Manjiri N Kamat's paper explored official plague and cholera control measures during the Pandharpur pilgrimage, and the indigenous reactions to them, in the period 1908–16. In epidemic years such as 1915 and 1916 a total ban was imposed on the religious fair. The paper argued that the Pandharpur Municipality, the railway authorities, the priestly families and the pilgrims contested these policies indirectly. This strategy of evasion – rather than overt confrontation – proved extremely useful in a context where local officials were willing to bend the rules prescribed by the authorities in Bombay, but were less amenable to violent demonstrations against administrative bans.

Panel 2 focused on kala-azar (visceral leishmaniasis) and leprosy in colonial India. Achintya Kumar Dutta's (University of Burdwan) paper dealt with kala-azar in colonial Eastern India. The disease was most severe in the tribal areas of Assam. A Kala-Azar Commission was appointed in 1924, but when it came to controlling the spread of the disease, government funds proved inadequate and the rural areas were scarcely reached.

Shubhada Pandya (Mumbai) examined the Propaganda Treatment Survey scheme for "ridding India of Leprosy", which was launched by the Indian Council of the British Empire Leprosy Relief Association in 1925. By viewing the scheme against the backdrop of the public health administration set up during provincial dyarchy (1920–35), the paper proposed three reasons for the failure of Ernest Muir's initiative: first, the inability to integrate its pattern of work into that of cash-strapped or unreceptive provincial public health services; second, the determined reluctance of the central Government to adopt a coordinative role; and third, the failure of the chaulmoogra/hydnocarpus regimen to live up to exaggerated claims made by its promoter, Leonard Rogers.

The last panel included presentations pertaining to smallpox in colonial India and Unani medicine in India. Paul Greenough (University of Iowa) was unable to attend due to unforeseen circumstances, so his paper was read by Priti Anand. It discussed smallpox vaccination in early colonial India, and the problems faced by the Tikadars (a group of professional inoculators). In Bengal, pamphlets were circulated in local languages to publicise vaccination and denigrate variolation. The rate of success was higher in the cities than in the countryside.

Sanjoy Bhattacharya's (Wellcome Trust Centre for the History of Medicine at UCL) presentation was based on the control of smallpox in colonial India. He argued that the range of civilian responses to vaccination was complex, and stressed the relative success of control measures in urban areas. He added that not all arms of the colonial State were receptive to the vaccination campaign. The paper articulated the political, scientific and technological factors affecting the success of vaccination, as well as the cultural and religious dimensions.

Kristin L Bright (State University of New York) presented the last paper, on Unani medicine in India. She discussed its contemporary relevance in the context of globalisation, and explained its popularity in light of the high cost and perceived side-effects of conventional medical treatment. She situated Unani's increasing marketability in the current scenario of India emerging as a favourite destination for medical tourism, especially among the affluent non-resident Indians.

In suggesting new avenues for research, participants agreed that the history of medicine in independent India merited more scholarly attention than it has hitherto received. The role of the Government of India, as well as international agencies, in the control of epidemic diseases was one area that prospective scholars could investigate. Last but not least, a persistent weakness in existing works on colonial and post-colonial India was the relative neglect of vernacular sources and oral history. Future researchers could redress this imbalance, thereby paving the way for the construction of richer and more authentic histories of medicine in South Asia.

Dr Manjiri N Kamat is a lecturer at the Department of History at University of Mumbai, India (**E** mnkamat@yahoo.com).

# Chinese medicine: a visual history

**WILLIAM SCHUPBACH**

**This conference, which took place in the beautiful Fragrant Hills Park on the outskirts of Beijing in September 2005, thanks to generous funding from the Wellcome Trust, had several items on the agenda.**

One was to celebrate the achievement of Professor Wang Shumin and her colleagues at the China Academy of Chinese Medicine in mounting on the Wellcome Library website 1400 images of woodcuts, drawings and paintings from the Library of the Academy that have a bearing on Chinese medicine and natural history (search for 'Wang Shumin' at http://medphoto.wellcome.ac.uk). Another was to start to analyse some of these and similar pictorial works: where do they come from (in every sense)? Why were they necessary? How do they relate to each other and to the wider world? In addition, the meeting honoured Professor Ma Jixing, of the China Institute for the History of Medicine and Medical Literature, China Academy of Traditional Chinese Medicine, who gave the most wide-ranging paper of the conference, on the ubiquitous iconography of the Emperor Yan (Shen Nong), from tenth-century paintings to shop signs in the modern high street.

The methodologies of the papers varied widely. Some described archaeological excavations, with the associated excitement of discovering authentic antiquities. Others, taking literary sources as their subject, were able to proceed from the bibliographic evidence to the task of analysing the cultural signifiers within book illustrations (of the pulse, acupuncture, smallpox, gymnastics, animals and many other subjects that have a bearing on medicine). Even here, however, for example in discussions of Japanese woodcuts of the pregnant woman, the venerable textual-critical technique of stemmatics was called in aid to explain the descent of the pictorial tradition. Wall paintings, thankas and engravings were the subject of iconographic analysis and geographic contextualisation.

**Right:** Illustration of medicinal liquors from *Shiwu benaco*, a dietetic herbal from the Ming period.

Globalisation was a theme that cut across all disciplines. Hal Cook's (Wellcome Trust Centre for the History of Medicine at UCL) paper set out a number of methodological options, showing the difficulty of achieving even-handed treatment of the relations between two or more parts of the world, the results of biting off more than one can chew, and (to change the metaphor) the need to use a brush neither too broad to depict significant detail nor too thin to provide narrative sweep. Later speakers showed their individual solutions to the problem by relating aspects of Chinese culture to specific other parts of the world, including Tibet, the UK (as illustrated by Patrick Manson's work in Amoy), Taiwan, Japan, and the Koreans in Japan and Manchuria.

It was interesting to see that, as in similar Western conferences, even though the focus is on non-literary documents, in practice the attempt to concentrate on the visual as distinct from the written usually collapses. Documents such as prints (which account for most of the illustrations in printed books) and drawings (which account for most of the illustrations in manuscript works) cannot be considered as visual works in isolation from the written parts of the book or manuscript, for the text is apprehended visually just as much as the illustrations. While basic studies such as analyses of paints or some aesthetic appreciations may ignore texts, bindings and provenance, as soon as an attempt is made to consider the works historically, any related evidence can and must be brought to bear on the illustration. Perhaps we are too easily ensnared by the ambiguous English word 'image', which is widely used to mean sometimes the disembodied image (including the digital reproduction of a woodcut, for example) and sometimes the corporeal entity such as the woodcut itself. Yet the woodcut is not so much the image as the vehicle for the image, and for its associated lettering. Indeed, Professor Wang showed that 'illustration and text supplement each other' really is an old Chinese saying.

In taking a wide range of pictorial genres – cave paintings, watercolour portraits, half-tone advertisements in newspapers and magazines, flow charts, sculptures, and cartoon-books – the conference demonstrated that, for the historian, these primary works can only to a limited extent be reduced to images. Their character is determined to a large extent by their medium, their genre, and their place of production. Where images in the sense of digital images or reproductions excel is in their didactic power and their ease of transmission, including communication beyond and outside their original context. Without the use of such surrogate images, the conference would have been deprived of a lavish visual feast. All those attending will be grateful to the organisers, Professor Wang and our hosts in Beijing, and Vivienne Lo and colleagues at the Wellcome Trust Centre for the History of Medicine. Publication of papers from the conference is in preparation.

Dr William Schupbach is Iconographic Collections librarian at the Wellcome Library, UK (**E** w.schupbach@wellcome.ac.uk).

# The League of Nations Archives, Geneva

**KAI KHIUN LIEW**

Despite being commonly associated with the failure of international diplomacy during the inter-war years, the League of Nations (LON) made significant progress in obtaining intergovernmental cooperation for its social and technical programmes during this period.

Among such projects was the active promotion of international public health and medicine, predominantly by the League's Health Committee and Health Section, which were established in 1923 under the 1922 covenant on the prevention and control of diseases.

Acting as links between national governments, these health services not only facilitated the flow of information and the provision of technical assistance, but also commissioned extensive studies on health-related issues. Auxiliary organisations included the Far Eastern Bureau and Epidemiological Station in Singapore, a State Serum Institute in Copenhagen, and a National Institute for Medical Research in London. Health and medical issues were also extensively discussed in other forums, such as the Commission for International Trafficking of Women and Children, and the Commission for the Trafficking and Consumption of Opium.

As a result, within a few decades, the LON had generated extensive primary materials in the forms of published reports, official meetings and secretariat files. While scattered materials are available in many libraries, a more complete archival collection of the LON has been stored in the library of the United Nations Office at Geneva, Switzerland. A separate reading room away from the main UN library is allocated for readers consulting the LON Archives. Visits are by appointment only, Monday to Friday (see www.unog.ch/library or email libraryarchives@unog.ch). The library can readily be reached by public transport, and access to most published reports and other correspondences is generally open. Although they have yet to be digitally catalogued, references to these materials are well organised. In this respect, the library staff are helpful and knowledgeable, and they have kept most of these materials are in relatively good and complete condition. At the moment, there are no facilities for the photocopy of materials although other modes of duplication (such as digital cameras) are permitted. The main languages of these reports and correspondences are French and English.

In general, these resources provide crucial insights into more than the institutions of the LON. The Archives would appeal to many historians of medicine, with materials from extensive country or regional studies of infectious diseases to data on health statistics and even surveys on medical treatments. Hence, no works on the historical understanding of health and diseases during the first half of the 20th century would be complete without exploring the materials generated by the LON.

Kai Khiun Liew is a doctoral candidate at the Wellcome Trust Centre for the History of Medicine at UCL.

# Oxford Dictionary of Scientific Quotations


**DIANA E MANUEL**

This work is a splendid addition to the series of Oxford dictionaries of quotations, and although its gestation might seem to have been somewhat lengthy, it has been worth waiting for.

Lady Judith May, to whom Bill Bynum generously attributes the original idea for a separate dictionary devoted to scientific quotations, is to be congratulated – as is Bynum himself for running with the idea and persuading his brilliant colleague and friend the late and much-lamented Roy Porter to join him as co-editor. These two distinguished scholars were assisted by an eminent panel of advisers and later by two colleagues, Sharon Messenger and Caroline Overy, who joined them as assistant editors. To them much credit is due.

The scope of this work is impressive, made possible by the breadth of the editors' conception of what constitutes science. They embrace the manifold contexts of science over time, including its philosophical, historical, sociological and literary dimensions. Thus while the term 'scientist' is a 19th-century construct, we have here key quotations on the genesis of ideas in science from the classical period to the present day. The editors have also paid attention to comments on science – often wittily and perceptively made by non-scientists, sometimes with tongue in cheek. C P Snow would have applauded this bringing together of the so-called two cultures of our highly specialised scientific and technological age.

Brought up in a culture permeated with literary quotations – including those from poetry and drama that are often one-liners committed perforce to memory – there may be some surprise that while there are some excellently brief ones on science here, some of the inclusions are of a length that might designate them as extracts. But they add to the richness of the collection as a whole, and while eminent scientists such as Sir Peter Medawar could when appropriate write eloquently, elegantly and concisely, the sciences are difficult and their concepts are not communicable by a series of soundbites alone.

The year 2005 saw an increased interest in books on science. It is therefore to be regretted that this book was not published simultaneously in both hard- and soft-backed covers. It would have made a great stocking-filler.

Bynum WF, Porter R (eds). Oxford Dictionary Of Scientific Quotations. Oxford: Oxford University Press; 2005.

Dr Diana E Manuel is an Honorary Senior Research Fellow at the Wellcome Trust Centre for the History of Medicine at UCL, UK (**E** d.manuel@ucl.ac.uk).

# Conference: Approaches to Ancient Medicine

## University of Reading, 21–22 August 2006

**The next seminar in the series alternating between the University of Newcastle upon Tyne and the University of Reading will be hosted by the Classics Department at Reading on 21–22 August 2006.**

It will commence at 13.00 on 21 August with a buffet lunch, followed by papers at 14.00. On 22 August, papers will begin at 09.00 and end at lunchtime; again, a buffet lunch will be provided but those needing to catch a train will be able to take food and go promptly. Dinner, overnight accommodation and breakfast will be available at Whiteknights Hall. The estimated total cost will be £70 to include a standard room, £90 for an *en suite* room. At this stage, it would be helpful if anyone interested in offering a 20-minute paper could contact Helen King at the address below.

Full proposals, with a provisional title and a summary of up to 200 words if possible, should be submitted by 30 April 2006 at the latest. We are looking for a wide range of disciplinary and methodological approaches. Papers from those new to the field of ancient medicine are particularly welcome.

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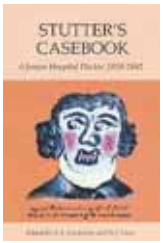
# Stutter's Casebook: A junior hospital doctor, 1839–1841




**CHRISTOPHER LAWRENCE**

Sometimes a really good piece of medical history comes at you sideways: unexpectedly and from nowhere. Not that Suffolk is nowhere, but the editors of this super little book were previously unknown to me.

W G Stutter (1815–1887) was a GP in a Suffolk village. From 1839 to 1841 he was House Apothecary and House Surgeon to the Suffolk General Hospital in Bury St Edmunds. This is an annotated transcription of his casebook from those years. The volume has an excellent short introduction, providing an account of both Stutter and the general background, enriched with anecdotal insights into rural medical life (the work is testimony to how much material lies in, for instance, local newspapers).

When full, the hospital (a converted ordnance depot) could house 53 patients. Its admission policy seems to conform to the picture we have of voluntary hospitals: for example, excluding the incurably sick and infectious cases. Patients had to be recommended, and admission and discharge was by committee. Stutter had the hallmark GP's qualification of the day: LSA, MRCS. At the hospital Stutter received a salary of £70 per annum (remarkably generous, I thought, although it is not clear whether he lived in). The hospital had two resident pupils in Stutter's day and was home to a medical book club.

Stutter's vade mecum contains around 70 medical cases. There were no surgical cases, although there were surgical patients in the hospital. Many of the cases are acknowledged by no more than a name and a prescription, but there are lots with a history and a continuing record of their medication, and occasional clinical observations. In fact, Stutter generally seems to have used the casebook primarily as a record of prescriptions (presumably either his own or those of the consulting physician). To those for whom the language of apothecaries is a foreign tongue, many pages of the original casebook would have been indecipherable. But, in what seems a Herculean labour, the editors have translated these – although, even in English, to me the significance and merit of prescribing "5 drachms Spirit of Nitrous Ether" is unclear. They have also provided an extensive appendix on 'Drugs and Chemicals'. The casebook is a salutary reminder of the centrality of therapy to past practice: a therapeutic approach not confined to a single prescription but making frequent withdrawals of ammunition from a huge arsenal of drugs and physical therapies.

The few patients with named diseases had the usual array of conditions one might expect: eczema, chlorosis, chorea, rheumatism, abscess etc. The histories have a distinct 18th-century 'feel'; the absence of diagnostic labels in many instances feeds into this sense. W Leech's (age 38) entry reads: "A blacksmith. Has enjoyed robust health all his life till 11 weeks ago when he was seized with a cold chill, succeeded by fever and Rheumatism." Is the latter a symptom or a disease? Or is this an anachronistic distinction on my part? Stutter physically examined his patients: he percussed their chests and listened to their hearts, presumably with a monaural stethoscope; he recorded abdominal girth before and after paracentesis. The word transitional sticks in the throat but it does convey where these histories are hanging. This work will be superb for teaching purposes. Carefully edited and meticulously footnoted, academic historians (and certainly PhD students) can learn a lot in more ways than one from this labour of love from two 'amateurs'.

Cockayne EE and Stow NJ (eds). Stutter's Casebook: A junior hospital doctor, 1839–1841. Suffolk Records Society vol. XLVIII. Woodbridge, Suffolk: The Boydell Press; 2005.

Professor Christopher Lawrence is Professor Emeritus at the Wellcome Trust Centre for the History of Medicine at UCL, UK (**E** christopher.lawrence@ucl.ac.uk).

# Prize announcement

The Director of the Wellcome Trust Centre for the History of Medicine at UCL is delighted to announce that the Roy Porter Memorial Prize 2005 has been awarded to Rohan Deb Roy, a first-year PhD student at the Centre. The Prize was established by public subscription in 2002 to commemorate the life and work of Roy Porter following his untimely death in that year. The prize takes the form of a travel grant, and Rohan will be using his award to undertake research at a number of archives in and around Calcutta in the autumn of 2006. On his return he will be invited to speak about his research on malaria and debility in colonial India as part of the Centre's Work in Progress series.

# Walking the Paris Hospitals: Diary of an Edinburgh medical student, 1834–1835

**WALTER M ROBINSON**

The abundance of first-hand accounts of medical training stands in contrast to the paucity of similar accounts for the humanities: there is a host of medical student diaries, yet we rarely read similar accounts of graduate training in history or philosophy. The reason is not that training in history or philosophy is uninteresting, but that training in medicine involves acquisition of a powerful (and, for many, mysterious) professional role.

The student enters medical training as a member of the public and exits initiated into a society of experts sanctioned to wound us for our own good, to judge our sanity, to prolong life or forestall death. Moreover, the means of this transformation involve probing around in bodies living and dead, learning to uncover deeply private secrets, and delivering potions of sometimes uncertain provenance to a willing public: who wouldn't be interested in that?

It is in the context of this fascination with medical education that the diary of a medical student in 1834 Paris, as uncovered and annotated by Diana Manuel of the Wellcome Trust Centre for the History of Medicine at UCL, arrives as a supplement to *Medical History*. The diaries cover the daily experiences of an Edinburgh-trained English student in Paris during the winter of 1834–35. While the identity of the diarist is not certain, Manuel makes a convincing argument that he is James Surrage of Clifton in Gloucestershire.

What attracts us, as historians, to read the diary of the everyday man? The cacophonic howl of self-revelation that reverberates from the blogging parts of the internet these days is ample proof that for a contemporary the daily experiences of many are achingly banal – there is one young man who photographs his every meal for our viewing pleasure. While we might rightly feel that viewing a daily parade of tacos is numbingly pointless today, the historian of 2171 might find it remarkably revealing of the social habits of the industrialised technorati, or he might use it as evidence of the fully saturated lifestyle that eventually led to government restrictions on diet. For these diaries of the daily listing sort, the interest grows with time and social distance from the diarist.

In some ways, the diary reproduced in this volume recalls those endless snapshots of dinner. The diarist's style is not self-examination but reportage: he makes entries every day without fail, and records the clinical cases he sees as well as the various therapeutic approaches employed by the professors. Only occasionally does he give us a glimpse of his interior life or comment on non-clinical events. He attends church services and reports on the sermon, encounters friends in whose company he appears to delight, and describes what could have been a fatal injury during a dissection with almost deadpan clarity. He indulges in harsh criticism of some of his professors, and indeed repeatedly hopes that murder charges will be brought against one; yet he writes approvingly of others who demonstrate either clinical success or pedagogic clarity.

The blogging parts of the internet these days are ample proof that for a contemporary the daily experiences of many are achingly banal

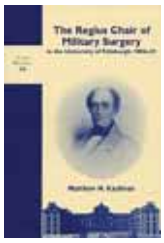
These opinions rest on a clear understanding of his own self-interest, as he is unforgiving of a less than punctual professor and of the crowds of fellow students around the diseased limbs and torsos on display. On the evidence of his words gathered here, he is not much a likeable chap. As a whole he exhibits the certainty of a young man of his class: he is as clear in his religious preferences as he is in the dismissal of others', he disdains the skill of the Gallic waiter and hotelier, and generally finds his adopted city inferior. His only concession to the adventure of living abroad seems to be a marked fondness for *oeufs à la neige* (floating island dessert).

In spite of this, Manuel makes the volume intriguing, not simply by her expert explications of the various clinical conditions encountered by our diarist and the available instruments he might use to address them, but also by a meticulous re-creation of the physical and social world of the foreign medical student in Paris at the time. Her extensive, well-researched, and well-written introduction and annotations make up for the diarist's laconic and somewhat repetitious style. That we come away with a better understanding of early 19th-century medical training is entirely owing to her skilful efforts. Like the diarist's beloved dessert chef, she can make a delight out of a sparse cupboard.

Manuel DE (ed.). Walking the Paris Hospitals: Diary of an Edinburgh medical student, 1834–1835. Medical History Suppl 23. London: Wellcome Trust Centre for the History of Medicine at UCL; 2004.

Walter M Robinson is an assistant professor of medical ethics and paediatrics at Harvard Medical School, USA, and a doctoral student at the Wellcome Trust Centre for the History of Medicine at UCL, UK (**E** walter-robinson@hms.harvard.edu).

# The Regius Chair of Military Surgery in the University of Edinburgh, 1806–55




**RICHARD BARNETT**

Between its establishment in 1806 and the withdrawal of government funding in 1855–56, as the British medical service in the Crimean War reached its catastrophic nadir, the Regius Chair of Military Surgery at the University of Edinburgh introduced several generations of Scottish medical students to the demands of operative practice on the field of battle.

For the half-century of the Chair's existence its occupants, John Thomson and George Ballingall, exercised through their teaching a unique influence over the surgical practices of the Army, Navy and East India Company medical services.

**Above:** Field surgery in the Dardanelles, 1915.

In this volume Matthew Kaufman, himself a Professor of Anatomy at Edinburgh, has two aims: to provide a short history of the establishment, influence and eventual dissolution of the Chair; and, following Stephen Jacyna and Michael Barfoot's accounts of Thomson's life and work, to document and contextualise Ballingall's career. The sources for this second task are, as Kaufman acknowledges, limited: little exists outside of Ballingall's textbooks and lectures, his scrapbooks of letters to newspapers and journals, and the case records sent to him by his former students. Presented on its own this material would make dry (not to say short) reading, but by integrating his account of Ballingall's life with (for example) the wider political context of the Chair and with a demographic analysis of military surgeons in the period, Kaufman builds against the usual historiographical caveats associated with individual biography.

Unsurprisingly, war – for its impact on both public policy and medical practice – is the spine of Kaufman's book. He traces the foundation of the Chair to British experiences in the early Napoleonic wars. In a memorandum to the First Sea Lord, the Edinburgh surgeon and extramural lecturer John Bell described his work as a military surgeon in the bloody aftermath of the naval battle of Camperdown (1797). Bell proposed the foundation of an entirely new School of Military Surgery, led by a professor who would not only "teach carefully the peculiar nature of gun-shot wounds" but also create a "short code of military medicine" to educate his students in "the fluxes, fevers, spasms, infectious diseases…of the camp and hospital", not to mention "medical geography" and "the scurvy, ulcers, infections, and all the disorders most frequent in ships of war". Graduates of this school would transcend the traditional role of sawbones and carry the latest theories and practices to the battlefields of the Empire.

Though Bell's proposal was never fully realised, the establishment of a Regius Chair of Military Surgery at Edinburgh was a direct result of his efforts. Edinburgh was well placed to teach military medicine, with several wards in the Royal Infirmary dedicated to service cases, but ironically it was the University's academic structure that caused resistance to and ultimately the dissolution of the Chair. Jacyna and others have noted the tension between University appointees (selected by the staunchly Tory town council) and occupants of Regius chairs (chosen by national – frequently Whig – governments). In his exposition of Ballingall's activities Kaufman provides a splendid example of this tension in action: it seems that the near-constant criticism of Ballingall's competence by his contemporaries (in particular Professor James Syme) was a crucial factor in Peel's decision to withdraw government funding for the Chair after Ballingall's death in 1855 and to redirect the money into the new Army Medical School in London.

It is sometimes hard to imagine that there is anything left to say about medicine in Edinburgh in the late 18th and early 19th centuries, but Kaufman has shown that continued work in this field can pay off in spades. Given the recent historiographical interest in medical specialisation, it would have been interesting to hear his reflections on military surgery as a 'specialism' (though one might equally claim that any talk of specialisation in early 19th-century British medicine would be deeply anachronistic). Similarly, the place of British military surgery in the colonial project could have been covered in greater depth, albeit at the risk of stretching Kaufman's terms of reference. But these are minor quibbles. This excellent book has struck another blow against the obsolete distinction between 'academic historians' and 'practitioner-historians'.

Kaufman MH. The Regius Chair of Military Surgery in the University of Edinburgh, 1806–55. Clio Medica 69. Amsterdam/New York: Rodopi; 2003.

Richard Barnett is a doctoral candidate at the Wellcome Trust Centre for the History of Medicine at UCL, UK (**E** ucgarba@ucl.ac.uk).

# Calendar of events

TO ADD AN EVENT TO THE CALENDAR PAGE, PLEASE SEND DETAILS TO THE EDITOR, sanjoy.bhattacharya@ucl.ac.uk

## MAY 2006

**10** **Maternal Health in the 20th Century: International perspectives**
London School of Hygiene and Tropical Medicine
Contact: Ornella Moscucci (**E** ornella.moscucci@lshtm.ac.uk)

**11–13** **International Conference on the History of Suicide**
McMaster University, Hamilton, Canada
Contact: Dr David Wright (**E** dwright@mcmaster.ca)

**19** **History of Clinical Iatrogenesis: Before and after Ivan Illich**
Centre for the History of Science, Technology and Medicine, University of Manchester
Contact: Aya Homei (**E** aya.homei@manchester.ac.uk)

## JUNE 2006

**6** **The Narrative Nature of Clinical Cases (Professor Brian Hurwitz)**
Apothecaries' Hall, London
Contact: clerk@apothecaries.org

**16** **Health and Medicine in the Spanish Empire, 1492–1700: Discourses, practices and representations**
Wellcome Trust Centre for the History of Medicine at UCL, London
Contact: Carol Bowen (**E** c.bowen@ucl.co.uk)
www.ucl.ac.uk/histmed

**21** **Joint meeting at the British Society for the History of Pharmacy**
Royal Pharmaceutical Society of Great Britain, London
Contact: clerk@apothecaries.org

**27** **A Colonial Laboratory: Robert Koch and tropical medicine**
Centre for the History of Science, Technology and Medicine, University of Manchester
Contact: Julie Anderson (**E** julie.anderson@man.ac.uk)

**28–30** **SSHM Annual Conference**
**Practices and Representations of Health: Historical perspectives**
Centre for the History of Medicine, University of Warwick, Coventry
Contact: Molly Rogers (**E** molly.rogers@warwick.ac.uk)

## AUGUST 2006

**26–30** **International Congress on the History of Medicine**
Budapest, Hungary
Contact: Klara Papp (**E** info@ishm2006.hu) www.ishm2006.hu

## SEPTEMBER 2006

**18–19** **Importance of Place in Medical Practice**
Centre for Medical History, University of Exeter
Contact: Claire Keyte (**E** cfmhmail@exeter.ac.uk)

For a fuller listing of lectures, seminars, conferences and other events relating to the history of medicine, visit http://medhist.ac.uk/events.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## Submit

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*Wellcome History* is published three times a year: in spring (March/April), summer (July/August) and winter (November/December). Please send any contributions to the Editor, Sanjoy Bhattacharya, two to three months ahead of your intended publication date. The Editor maintains a strict first come, first served policy – so, if an article is sent after a particular issue has been filled, it will have to wait for publication in the next available issue.

Contributor guidelines are available at **www.wellcome.ac.uk/wellcomehistory**

Contributions should preferably be pasted into an email and sent to the Editor (**E** sanjoy.bhattacharya@ucl.ac.uk).



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